

- ☐ Application for Active Medical APRN Staff (form OCSHCN-60b)
Please sign and date (see last page)
- ☐ Signed Authorization, Attestation, and Release (form OCSHCN-60e)
- ☐ Signed Anti-Harassment and Discrimination Acknowledgment (form OCSHCN-60f)
- ☐ Copy of your current credentialing from the American Nurses Credentialing Center (ANCC) or the American Academy of Nurse Practitioners (AANP)
- ☐ Copy of the Collaborative Practice Agreement between the physician and yourself
- ☐ Copy of your current CAQH application
- ☐ Current Curriculum Vitae
- ☐ Copy of current malpractice insurance endorsement
- ☐ Copy of current Kentucky State license, RN and APRN
- ☐ Copy of current DEA certificate (if applicable)

APPLICATION FOR ACTIVE MEDICAL APRN STAFF

PEER REFERENCES: Please provide two (2) names of physicians or APRN, along with their institution, who have worked closely with you, and can comment on your professional skills.

Name: (Last) _____ (First) _____ (MI) ____

Institution Name _____

Institution Address _____
City State Zip Code Country

Name: (Last) _____ (First) _____ (MI) ____

Institution Name _____

Institution Address _____
City State Zip Code Country

APPLICATION FOR ACTIVE MEDICAL APRN STAFF

Please answer the following questions. For any “Yes” response, give full details on a separate sheet and attach to your application.

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|----|---|--|
| 1 | Has your license to as an APRN in any jurisdiction ever been denied, suspended, limited, revoked, or surrendered? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2 | Has your DEA license ever been denied, suspended, limited, revoked, or surrendered? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3 | Have you ever been convicted of a felony? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4 | Have your privileges at any hospital or institution ever been denied, suspended, limited, revoked or not renewed (for other than administrative reasons)? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5 | Have you ever resigned from a hospital staff or institution while under investigation regarding a breach of professional activity? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 6 | Have you ever been denied membership or a renewal thereof or been subject to disciplinary proceedings in any medical organization? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 7 | Are you now abusing, or have you ever been treated for abuse of, chemical substances? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 8 | Do you carry Medical Liability Insurance in an amount and kind that will insure protection of OCSHCN patients under your care? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 9 | Any claims within past 5 years? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 10 | Are there any pending claims? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 11 | Have you ever had malpractice or liability insurance coverage suspended or denied? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

NOTE: If there is any other significant information not asked on this page that should be known by the committee evaluating your eligibility for staff membership, please provide as an attachment to this application.

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I certify that all information provided by me in my application is current, true, correct, accurate, and complete to the best of my knowledge and belief, and is furnished in good faith. I certify that I have received a copy of the Medical Staff Policies. In making application for appointment to OCSHCN, I agree to abide by its medical staff's bylaws, rules and policies, to conduct my practice in accordance with high ethical traditions, and I pledge to provide continuous care for all my patients.

I further acknowledge and understand that my application does not guarantee that OCSHCN will grant me clinical privileges or contract with me as a provider of service.

Printed Name

Signature

Date